



HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, Idaho 83720-036 PHONE: (208) 334-6626 FAX: (208) 364-1888 E-mail: fsb@idhw.state.id.us

June 26, 2009

Tom Whittemore Communicare, Inc #2 Boone 40 West Franklin Road, Suite F Meridian, ID 83642

RE:

Communicare, Inc #2 Boone, provider #13G009

Dear Mr. Whittemore:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #2 Boone, which was conducted on June 22, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. <u>It is important</u> that your Plan of Correction address each deficiency in the following manner:

- 1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for <u>all</u> individuals potentially impacted by the deficient practice.
- 2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
- 3. Identify the date each deficiency has been, or will be, corrected.
- 4. Sign and date the form(s) in the space provided at the bottom of the first page.

Tom Whittemore June 26, 2009 Page 2 of 2

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **July 8, 2009**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by July 8, 2009. If a request for informal dispute resolution is received after July 8, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MONICA WILLIAMS Health Facility Surveyor

m. Williams

Non-Long Term Care

NICOLE WISENOR

Co-Supervisor

Non-Long Term Care

MW/mlw

Enclosures

JUL-15-2009 11:23A FROM: COMMUNICARE

208 888 1156

TD:3641888

P.1/17

CommuniCare, inc.

40 West Franklin, Unit F Meridian, Idaho 83642

Phone (208) 888-[155 Fax (208) 888-1156

Date: 7-15-2009 Time: A.M./P.M. Fax #: 364-1888
To: Monica Williams, Surveyor
Subject: CCI#2 POC
From: Tomwhittemore
Comments: Thanks for the extension -

TO: 3641888

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2009 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		13G009	B. WIN	G_	06/22/2009		
	ROVIDER OR SUPPLIER	DNE		12	EET ADDRESS, CITY, STATE, ZIP CODE 210 W BOONE ST AMPA, ID 83651		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 000	annual recertification The survey was commonica Williams, Output Troutfetter, Qiff Common abbreviated ADHD - Attention of AQ - Assistant Quarofessional BMP - Behavior Months of ABMP - Behavior Months of ABMP - Behavior Months of ABMP - Qualified Professional ABMP - Qualified Professional ABMP - Qualified Professional ABMP - Qualified Professional ABMP - ABM	ciencies were cited during your on survey. Conducted by: CMRP, Team Leader MRP Itions used in this report are: Deficit Hyperactivity Disorder alified Mental Retardation anagement Program pogram Plan actical Nurse ise Specified Mental Retardation ENT RECORDS evelop and maintain a tem that documents the client's treatment, social information,	w c	To change	W111 Corrective Actions: Individual #1: A medication reduplan was redone by the QMRP Supervisor 03/24/09 which has to correct diagnostic information be on a clarification meeting with the psychiatric services provider in December 2008 which is document apparently was not attached to to official copy of the BMP in the permanent record but is attache review. The informed consent wobtained prior to this diagnostic clarification (12/08) but did reflecting to the permanent used to the diagnostic information being used to the permanent record but is attached to the	the ased e e ented upport the d for vas	8/22/2009
	a 36 year old male	diagnosed with profound			TOTAL C		(X8) DATE
		IDER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE	ار	istalor_	7-15	-2009
1111	n (llllette)		M	11	career -	-,,,,	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents ere made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 220D11

Facility IO: 13G009

If continuation sheet Page 1 of 14

TD:3641888

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		13G009	B. WI	4G _	<u> </u>	06/2	2/2009
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #2 BOONE				1.	REET ADDRESS, CITY, STATE, ZIP CODE 210 W BOONE ST NAMPA, ID 83651		
PREFIX (EACH I	DEFICIENC'	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
NOS. Reverthe following a. Individual Reduction received E Catapres in diagnoses intermitten. However, linclude important interview of LPN stated disorder as b. Individual revised 1/0 Effexor an NOS. However, Authorizated 10/1/08, do "assist he particularly ADHD." However, diagnosis on 6/22/09 stated the Managem and intermited for Individual c. Individual c. Individual received as a second received received as a second received received as a second received r	ardation, view of Inning concernal #1's P Plan, da ffexor (a Patch (ar of impulse conformation of impulse conformation of impulse conformation of impulse conformation of the wasta diagram of the product of the produc	autism, and mood disorder dividual #1's records showed	W	111	when it was developed (10/0) use of Xanax for all medical appointments will be clarified however, we have not been considering a hearing appoin specifically as a medical appointment as an assessment. Informed consents will be repwith correct diagnostic information the medication reduction plan updated related to which appointments (medical verse assessment) for which a premedication is medically necessation is medically necessation in the medical was assessment for Individual #4 occurred. This is an oversigh part. Upon person #4's admissioner presented immense maladap behavioral concerns which reimmediate attention by our stratef from other agencies as wellingently strove to meet his moritical needs his PT evaluation to scheduled. It now has be scheduled. This is an unusual situation and we have policies requiring initial evaluations be routinely completed prior to the Day Staffing. Identifying Others Potentially Psychiatric diagnostic informatical reviewed for all individual's light the Sun Health psychiatric services provider, the QMRP Supervisor, and the RN Supervisor, and the RN Supervisor, and the loss of the tobe related to the loss of the	tment continent rocessed ation and a will be seary. herapy has not t on our esion he tive quired aff and ve nost on was en al sein effect de ag ation was ring at heeting fic rivisor. appears	

TO:3641888

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 111	the AQ and a direct were present during Individual #1 was n appointment. d. The Psychoactive Informed Consent, Individual #1 received drug) to decrease a procedures that decarea." However, during an 10:45 - 11:50 a.m., only used for denta. The facility failed to system that contain Information for Individual #4's IP a 17 year old male mental retardation, and intermittent expadmitted to the facility failed to the facility failed to the facility failed to system that contain Information for Individual #4's Com Assessment (CFA) CFA stated he was cards and schedule speech therapist ar However, no such this record. Further could not be found	decomplish testing. Seed on 6/17/09 at 11:30 a.m., a care staff both stated they give the hearing evaluation and out restrained during the Medication Authorization and dated 10/1/08, documented ed Xanax (an anti-anxiety inxiety during "all medical at with his head and face Interview on 6/18/09 from the LPN stated Xanax was appointments. maintain a record keeping ed accurate and complete vidual #1. P, dated 3/25/09, documented diagnosed with moderate oppositional defiant disorder, plosive disorder. He was lity on 2/24/09. Apprehensive Functional was attached to his IPP. His starting to use communication as as recommended by the doccupational therapist. Evaluations could be found in a physical therapy evaluation	W	III	medication reduction plan and have not been affected. System Changes: See "correactions". Monitoring: See "corrective ad In addition the Quality Assura review system will be schedul semi-annual rather than annual and listed on the annual calent insure periodic reviews occur.	ctive ctions". nce ed on a al basis dar to	

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		13G009	B. WING		06/:	22/2009	
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #2 BOONE				STREET ADDRESS, CITY, STATE, ZIP CODE 1210 W BOONE ST NAMPA, ID 83651			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(D PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 111	interview on 6/18/09 above noted evaluate first thirty days or reports had been re The facility failed to contained evaluation status.	From 11:15 - 11:25 a.m., the dions were conducted within of admission, but no formal eceived. ensure Individual #4's record ins that reflected his current	W 1			7/13/2009	
	integrated, coordinated qualified mental retained the QMRP provided suit individuals (Individuals (Individual	P, dated 4/2/09, documented diagnosed with moderate autism, and generalized aries, dated 7/08 - 4/09, g inappropriate revisions to as. Examples included, but		Corrective Actions: We have system in place which speci updating and monitoring prowell as QMRP oversight of the system. Issues noted appear combination of the need for inservice training for the QM House Manager, and Instruct Leadworker at this location and need for an increase in period monitoring. As of 07/09/09 abased programs developed 04/09 annual staffing have be reviewed either by the QMR Supervisor or Quality Assura QMRP to insure a match with statements. One of these management level employed participate in the monthly reprocess and generation of months or until satisfied that management level understated can properly implement estated the individuals at this home level.	fies the cess as his ar to be a more RP, ctional and the odic all data from the been P ance h goal es will view nonthly ext three and and ablished	5	

208 888 1156

FORM CMS-2567(02-99) Previous Versions Obsalele

Event ID: 220D11

Facility ID: 13G009

If continuation sheet Page 4 of 14

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #2 BOON	E	•	121	ET ADDRESS, CITY, STATE, ZIP CODE 10 W BOONE ST MPA, ID 83651		
PREFIX (EACH DEFICIENCY N	SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		ULD BE	(X5) COMPLETION DATE
6/22/09 at 12:45 p.m percentage to the oblindividual #3's Annual showed he met and/od/4/09. In sum, the prostep one even though 5/08. - The Wash Hands posses for 2 consecutive #3 met the first mont in 10/08, the objective the program started of stated on 6/22/09 at the percentage to the individual #3's Annual showed he exceeded sum, the program was even though criterial in the program was even though criterial in the percentage to the individual #3's Annual showed he exceeded sum, the program was even though criterial in the program was prior to individual #3 current step. When a 6/22/09 at 12:45 p.m have been revised in the Money program 2 consecutive month at 0%. However, in 9 to the next step prior criteria at the current stated on 6/22/09 at should not have been 2. Individual #1's IPP	asked, the LW stated on i., he forgot to add the spective in 7/08. However, al Summary Overview or exceeded 88% from 5/08 - ogram was started over at h criteria had been met since or ogram criteria was set at we months. In 9/08, Individual the of the objective on Step 4. We was changed to 88% and over. When asked, the LW 12:45 p.m., he forgot to add the objective in 7/08. However, al Summary Overview d 88% from 5/08 - 4/09. In the started over at step one had been met since 5/08, arm criteria was set at 88% onths. However, in 11/08 and its revised to the next step meeting criteria at the asked, the LW stated on in the program should not in 11/08 and 2/09. The criteria was set at 88% for its in 8/08, Individual #3 was 19/08 the program was revised to Individual #3 meeting it step. When asked, the LW 12:45 p.m., the program	W 1	59	Identified as potentially affected System Changes: There will I changes in the current system changes will be in training and monitoring this system. Monitoring: See "corrective as a system of the current system of the	be no n; the si	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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W 159	mental retardation, NOS. His Monthly Summa showed the followin his training program were not limited to, - The Dining program consecutive months and data for 11/08 sprogram was revise effective 12/08. - The Oral Care profor 2 consecutive months and data for 9, the program was refective 10/08. - The Shaving prog 2 consecutive months and data for 1, the program was reffective 2/09. During an interview p.m., the LW stated should not have been 3. Individual #2's IP a 40 year old femal mental retardation at the Monthly Summa showed the followin	autism, and mood disorder aries, dated 7/08 - 4/09, ag inappropriate revisions to as. Examples included, but the following: m criteria was set at 88% for 2 as. Data for 10/08 showed 63% showed 75%. However, the ad from Step 2 to Step 3 agram criteria was set at 88% conths. Data for 8/08 showed and showed 100%. However, avised from Step 2 to Step 3 aram criteria was set at 88% for and criteria was set at 88% conths. Data for 12/08 showed and showed 100%. However, avised from Step 2 to Step 3 and 6/22/09 from 12:40 - 1:20 at the programs listed above been revised. P, dated 4/2/09, documented and seizure disorder. aries, dated 7/08 - 4/09, ag inappropriate revisions to ans. Examples included, but	W	159			
		Laure Park Control of the Control of	100				

FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '			COMPLETED	
	13G009	B. WI	1G	<u> </u>	06/2	2/2009
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #2 BOONE			12	210 W BOONE ST		
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
- The Dressing profor 2 consecutive mow, 11/08 data showed 0%. Howe from Step 3 to Step - The Wash Hand pages for 2 consecut showed 62% and dhowever, the prograte 2 effective 3/0 During an interview p.m., the LW states should not have be The facility failed to Individual #1 - #3s' monitored and app 483.440(e)(1) PRO Data relative to acc specified in client in objectives must be terms. This STANDARD Based on record rewas determined the was collected on prindividuals (Individuals Cummaries were redata consistently hability of the IDT in programmatic tech	gram criteria was set at 75% nonths. Data for 10/08 showed bywed 63%, and data for 12/08 over, the program was revised of 4 effective 1/09. Program criteria was set at tive months. Data for 1/09 lata for 2/09 showed 94%. Fam was revised from Step 1 to 199. Programs listed above en revised. Programs were repriately revised. Programs were repriately revised. Programs listed above en revised. Pr			W252 Corrective Actions: Managementare expected to check for adect documentation by the 15 th of the month. Effective immediately, is not enough data collection, to QMRP, House Manager, and/will collect data themselves that the end of the month until sufficient data probes are documented, addition, the QMRP Supervisor meet with this management tead determine what other actions with the implemented to insure that a significant problem. The complete this activated in the complete this activa	quate ne if there he or ILW ough cient In r will am to vill be ufficient ire vity.	7/13/2009
1. Individual #1's If	PP, dated 4/2/09, documented			All individuals at this home have	ve been	
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa The Dressing profor 2 consecutive n 0%, 11/08 data sho showed 0%. Howe from Step 3 to Step The Wash Hand p 88% for 2 consecut showed 62% and d However, the progr Step 2 effective 3/0 During an interview p.m., the LW states should not have be The facility failed to Individual #1 - #3s' monitored and app 483.440(e)(1) PRO Data relative to acc specified in client in objectives must be terms. This STANDARD Based on record re was determined the was collected on p individuals (Individual Summaries were re data consistently ability of the IDT in programmatic tech	TIDENTIFICATION NUMBER: 13G009 PROVIDER OR SUPPLIER INICARE, INC #2 BOONE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 - The Dressing program criteria was set at 75% for 2 consecutive months. Data for 10/08 showed 0%, 11/08 data showed 63%, and data for 12/08 showed 0%. However, the program was revised from Step 3 to Step 4 effective 1/09. - The Wash Hand program criteria was set at 88% for 2 consecutive months. Data for 1/09 showed 62% and data for 2/09 showed 94%. However, the program was revised from Step 1 to Step 2 effective 3/09. During an interview on 6/22/09 from 12:40 - 1:20 p.m., the LW stated the programs listed above should not have been revised. The facility failed to ensure the QMRP ensured Individual #1 - #3s' training programs were monitored and appropriately revised. 483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 - The Dressing program criteria was set at 75% for 2 consecutive months. Data for 10/08 showed 0%, 11/08 data showed 63%, and data for 12/08 showed 0%. However, the program was revised from Step 3 to Step 4 effective 1/09. - The Wash Hand program criteria was set at 88% for 2 consecutive months. Data for 10/09 showed 62% and data for 2/09 showed 94%. However, the program was revised from Step 1 to Step 2 effective 3/09. 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The findings include:	PROVIDER OR SUPPLIER INICARE, INC #2 BOONE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 - The Dressing program criteria was set at 75% for 2 consecutive months. Data for 10/08 showed 0%, 11/08 data showed 63%, and data for 12/08 showed 0%. However, the program was revised from Step 3 to Step 4 effective 1/09. - The Wash Hand program criteria was set at 88% for 2 consecutive months. Data for 1/09 showed 62% and data for 2/09 showed 94%. However, the program was revised from Step 1 to Step 2 effective 3/09. During an interview on 6/22/09 from 12:40 - 1:20 p.m., the LW stated the programs listed above should not have been revised. 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WING	PROVIDER OR SUPPLIER INCARE, INC #2 BOONE SUMMARY STATEMENT OF DEPICIENCIES (RAND REPCIENCY MIST BE PRECEDED BY SULL REQULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 - The Dressing program criteria was set at 75% for 2 consecutive months. Data for 10/08 showed 0%, 11/08 data showed 53%, and data for 12/08 showed 0%. However, the program was revised from Step 3 to Step 4 effective 17/09. - The Wash Hand program criteria was set at 88% for 2 consecutive months. Data for 10/09 showed 52% and data for 2/09 showed 94%. However, the program was revised from Step 3 to Step 4 effective 17/09. - The Wash Hand program criteria was set at 88% for 2 consecutive months. Data for 11/09 showed 52% and data for 2/08 showed 94%. However, the program was revised from Step 3 to Step 4 effective 17/09. - The Wash Hand program criteria was set at 88% for 2 consecutive months. Data for 11/09 showed 52% and data for 2/08 showed 94%. 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		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		13G009	B. WING		and the second s	06/22/2009	
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W 252	mental retardation, NOS. Review of Individual showed the following being collected: The Bathing programonths 6/08 - 9/08. The Money programonths 2/09 - 4/09. When asked during 10:45 - 11:50 a.m., know what happened when asked, the Lip.m., there was no data on the money Individual #2's IP a 40 year old femalemental retardation and Review of Individual showed the following collected: The Shower programonths 7/08 - 9/08, not enough data for The Bathing programonths 6/08 - 9/08. The Communication	diagnosed with profound autism, and mood disorder I #1's Monthly Summaries ig programs with no data am was missing data for the im was missing data for the important data certified staff to collect program. P. dated 4/2/09, documented a diagnosed with severe and a seizure disorder. I #2's Monthly Summaries is programs with no data am was missing data for the and documented there was the months of 3/09 and 4/09. am was missing data for the	W	252	identified as potentially affect System Changes: See "correactions". Monitoring: Starting 07/09 et QMRP Supervisor or a Qualit Assurance QMRP will particit the monthly summary update for the next three months or satisfied that issues of adequal documentation are solved.	ective ther the ty pate in process until	

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NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #2 BOONE				12	EET ADDRESS, CITY, STATE, ZIP CODE 210 W BOONE ST AMPA, ID 83651	00/2	2/2008
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 252	programs all docum for the months of 2/ When asked during 12:40 - 1:20 p.m., the data certified staff to 3. Individual #3's IP a 33 year old male of mental retardation, anxiety disorder. Individual #3's Montand 3/09, showed in following programs: Janitorial, Voc/Offic When asked, the LN p.m., there was no data during the about the facility failed to specified in Individual 483.440(f)(3)(i) PROCHANGE The committee shomonitor individual properciate behave in the opinion of the client protection and the sased on observation.	nented insufficient data probes /09 and 3/09. I an interview on 6/22/09 from the LW stated there was no o collect data. P, dated 4/2/09, documented diagnosed with moderate autism, and generalized thly Summaries, dated 2/09 to data was collected on the Homemaking, Money, the and Perceptual Motor. W stated on 6/22/09 at 12:45 data certified staff to collect we noted months. ensure data was collected as tals #1 - #3s' IPPs. DGRAM MONITORING & uld review, approve, and rograms designed to manage vior and other programs that, to committee, involve risks to dirights.	W 2		W262 Corrective Actions: We were viethe addition of one-to-one staff a supportive rather than restrictive Now that this has been clarified this individual's BMP has been updated to clarify this as a restrictement and the consent for the will be reprocessed for HRC revithe QMRP. Identifying Others Potentially Affile	es for us ctive BMP iew by	8/22/2009
	interviews it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 1 of 4 individuals (Individual #4)				No other individual's have this ty support/restriction at this location	ype of	

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Event ID: 220D11

Fecility ID: 13G000

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		13G009	B. WING	hat was a second of the second	06/22/2009	
	ROVIDER OR SUPPLIER	NE	1:	EET ADDRESS, CITY, STATE, ZIP CODE 210 W BOONE ST IAMPA, ID 83651		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIÉS / MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	D PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
W 262	whose behavioral in This resulted in a la individual's rights the restrictive intervent. 1. Individual #4's IP a 17 year old male mental retardation, and intermittent expadmitted to the facing observation 6/15/09 and 6/16/09 and 6/16/09 at 1:30 p.m. one-to-one staff. V 6/16/09 at 1:30 p.m. one-to-one supervito his aggressive but Individual #4's BMF'One-to-one staffing other mention of BMP. Individual #4 approval from the fincreased supervis. When asked, the Conterview on 6/18/09 was obtain 6/18/09).	nterventions were reviewed. ack of protection of an arough prior approvals on ions. The findings include: P, dated 3/25/09, documented diagnosed with moderate oppositional defiant disorder, closive disorder. He was lity on 2/24/09. Is conducted at the facility on 9 for a cumulative 4 hours 48 #4 was noted to have when asked, the AQ stated on in, individual #4 was placed on sion from 9:00 a.m. to 9:00 y 6 weeks after admission, due ehavior. P, revised 6/09, stated g was assigned" There was fincreased supervision in the is record did not contain acility's HRC for the BMP or	W 262	System Changes: We will clause all QMRP's that one-to-one so a restrictive element which reinformed consent. Monitoring: Consent will be reduring the now scheduled set annual Quality Assurance revorcess which will be designated annual CCI calendars.	taffing is equires eviewed mi- view	
W 263	#4 prior to the inter	vention being used.	W 263	W263 Corrective Actions: We were v	iewing	7/13/2009
	The committee should insure that these programs			the addition of one-to-one staff	as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED		
		13G009	8. WING		06/2:	2/2009	
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #2 BOONE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				1	REET ADDRESS, CITY, STATE, ZIP CODE 210 W BOONE ST JAMPA, ID 83651 PROVIDER'S PLAN OF CORREC		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENT(FYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION OATE
W 263	are conducted only consent of the clien minor) or legal guar. This STANDARD is Based on observation interviews it was de ensure restrictive in only with the approvof 4 individuals (Indinterventions were relack of protection of prior approval of a refindings include: 1. Individual #4's IP a 17 year old male of mental retardation, and intermittent expladmitted to the facil During observations 6/15/09 and 6/16/09 minutes, Individual one-to-one staff. W 6/16/09 at 1:30 p.m. one-to-one supervisp.m., approximately to his aggressive be Individual #4's BMP "One-to-one staffing no other mention of BMP. Individual #4'consent from his legincreased supervision in the staff of the st	with the written informed t, parents (if the client is a rdian. Is not met as evidenced by: on, record review, and staff termined the facility failed to terventions were implemented val of the parent/guardian for 1 ividual #4) whose behavioral reviewed. This resulted in a fan individual's rights through restrictive intervention. The P, dated 3/25/09, documented diagnosed with moderate oppositional defiant disorder, plosive disorder. He was lity on 2/24/09. Is conducted at the facility on of for a cumulative 4 hours 48 #4 was noted to have hen asked, the AQ stated on in Individual #4 was placed on son from 9:00 a.m. to 9:00 for weeks after admission, due shavior. In revised 6/09, stated a was assigned" There was increased supervision in the its record did not contain gal guardian for the BMP or	W	263	supportive rather than restrict Now that this has been clarific this individual's BMP has been updated to clarify this as a reselement and the consent for will be reprocessed for legal or review by the QMRP. Identifying Others Potentially No other individual's have this support/restriction at this local System Changes: We will clar all QMRP's that one-to-one starestrictive element which recinformed consent. Monitoring: Consent will be reduring the now scheduled semannual Quality Assurance reviprocess which will be designated annual CCI calendars.	ed for us on strictive the BMP guardian Affected: s type of tion. arify for affing is quires eviewed one ew	

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		13G009	B. WI	۱G	Mark American	06/2	22/2009
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #2 BOONE				12	EET ADDRESS, CITY, STATE, ZIP CODE 210 W BOONE ST IAMPA, ID 83651		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CRÓSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	(X5) COMPLETION DATE
W 263	interview on 6/18/09 consent was obtain 6/18/09). The facility failed to obtained for increase #4 prior to the inter 483.450(b)(4) MGM CLIENT BEHAVIOI The use of systems inappropriate client incorporated into the	ef from 11:15 - 11:25 a.m., ed earlier that morning (on ensure guardian consent was sed supervision of Individual vention being used. TOF INAPPROPRIATE R	w a	e ambournessement	W289 Corrective Actions: We were vithe addition of one-to-one staff supportive rather than restrictive Now that this has been clarified this individual's BMP has been updated to clarify this as a restrelement.	as e. for us	7/13/2009
	Based on observation interviews it was desensure techniques behavior were incomposed for 1 of 4 individuals behavior intervention resulted in an intervent included in an infindings include: 1. Individual #4's IP a 17 year old male mental retardation, and intermittent expadmitted to the facion of 15/09 and 6/16/0 minutes. Individual	s not met as evidenced by: on, record review, and staff stermined the facility failed to used to manage inappropriate rporated into the program plan is (Individual #4) whose ons were reviewed. This sention being used that was individual's program plan. The off, dated 3/25/09, documented diagnosed with moderate oppositional defiant disorder, blosive disorder. He was lity on 2/24/09. Is conducted at the facility on off or a cumulative 4 hours 48 off			Identifying Others Potentially A No other individual's have this is support/restriction at this location. System Changes: We will clarical QMRP's that one-to-one state a restrictive element which must identified as such in individuals. Monitoring: The QMRP Superwill insure that one-to-one superist included as a restrictive elemental BMPs and QMRPs will revise BMPs developed by the QMRP Supervisor.	type of on. fy for fffing Is st be BMPs. visor ervision nent in ew all	

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Event ID: 220D11

Facility ID: 13G009

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		13G009	B. WIN	B, WING		06/22/2009	
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #2 BOONE				12	EET ADORESS, CITY, STATE, ZIP CODE 210 W BOONE ST AMPA, ID 83651		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	(X5) COMPLETION DATE
W 289	one-to-one supervis p.m., approximately to his aggressive be individual #4's BMF "One-to-one staffing no other mention of BMP. When asked, the Quinterview on 6/18/09 one-to-one supervisindividual #4's BMF issue. The facility failed to supervision was income.	., Individual #4 was placed on sion from 9:00 a.m. to 9:00 6 weeks after admission, due	W 2		W449		8/22/2009
	The facility must invevacuation drills and This STANDARD is Based on record redetermined the faci correct problems the quarterly evacuation (Individuals #1 - #8 findings include: 1. The facility's Evato 6/09 were review the following: - The night shift evices and the standard following:	vestigate all problems with d take corrective action. Is not met as evidenced by: view and staff interview, it was lity failed to take actions to at were identified during an drills for 8 of 8 individuals presiding in the facility. The cuation Drill Reports from 7/08 ared. The reports documented accuation, dated 7/24/08, accuation thme of 20 minutes.			Corrective Actions: We have a system for investigation of prolifire drills (see attached). The Manager and QMRP will be reinserviced as to this process. Identifying Others Potentially All individuals at this location a potentially affected. System Changes: There will be changes in the current system changes will be in re-inservicin monitoring this system. Monitoring: The Administrator establish a "problem" evacuation time for each shift and any drill	offected: are e no the gand will on drill	

FORM CMS-2567(02-99) Previous Versions Obsalete

Event 1D: 220D11

Facility ID: 13G009

If continuation sheet Page 13 of 14

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #2 BOONE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL) TAG W 449 Continued From page 13 - The right shift evacuation, dated 10/13/08, documented an evacuation time of 6 minutes. - The night shift evacuation, dated 4/15/09, documented an evacuation time of 8 minutes. - The night shift evacuation, dated 4/15/09, documented an evacuation time of 6 minutes. - The night shift evacuation, dated 6/3/09, documented an evacuation time of 6 minutes. - The night shift evacuation, dated 6/3/09, documented an evacuation time of 6 minutes. - The night shift evacuation, dated 6/3/09, documented an evacuation time of 6 minutes. - The night shift evacuation, dated 6/3/09, documented an evacuation time of 6 minutes. - The night shift evacuation, dated 6/3/09, documented an evacuation time of 6 minutes. - The night shift evacuation, dated 6/3/09, documented an evacuation time of 8 minutes. - The night shift evacuation, dated 6/3/09, documented an evacuation time of 6 minutes. - The night shift evacuation, dated 6/3/09, documented an evacuation time of 8 minutes. - The night shift evacuation asked during an interview on 6/16/09 from 10/46 - 11:50 a.m., the OMRP stated there was no corrective action was taken for evacuations with extended periods of time.	STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #2 BOONE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) TAG			13G009	e. Wi	VG _		06/22	2/2009
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W 449 Continued From page 13 The night shift evacuation, dated 10/13/08, documented an evacuation time of 7 minutes. The night shift evacuation, dated 12/22/08, documented an evacuation time of 6 minutes. The night shift evacuation, dated 4/15/09, documented an evacuation time of 8 minutes. The night shift evacuation, dated 6/3/09, documented an evacuation time of 6 minutes. However, there was no documentation of corrective action. When asked during an interview on 6/18/09 from 10:45 - 11:50 a.m., the QMRP stated there was no corrective action taken. The facility failed to ensure corrective action was taken for evacuations with extended periods of				STREET ADDRESS, CITY, STATE, ZIP CODE 1210 W BOONE ST				
with an analysis which will be submitted to him. The night shift evacuation, dated 10/13/08, documented an evacuation time of 7 minutes. The day shift evacuation, dated 12/22/08, documented an evacuation time of 6 minutes. The night shift evacuation, dated 4/15/09, documented an evacuation time of 8 minutes. The night shift evacuation, dated 6/3/09, documented an evacuation time of 6 minutes. However, there was no documentation of corrective action. When asked during an interview on 6/18/09 from 10:45 - 11:50 a.m., the QMRP stated there was no corrective action taken. The facility failed to ensure corrective action was taken for evacuations with extended periods of	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	CTION SHOULD BE THE APPROPRIATE	
	W 449	- The night shift evadocumented an evado	acuation, dated 10/13/08, acuation time of 7 minutes. cuation, dated 12/22/08, acuation time of 6 minutes. acuation, dated 4/15/09, acuation time of 8 minutes. acuation, dated 6/3/09, acuation time of 6 minutes. acuation time of 6 minutes. So no documentation of When asked during arium 10:45 - 11:50 a.m., the was no corrective action	W	449	with an analysis which will be	ed up	

Bureau of Facility Standards

P.16/17

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STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 13G009 06/22/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1210 W BOONE ST **COMMUNICARE, INC #2 BOONE** NAMPA, ID 83651 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID ID (X5) COMPLETE PRÈFIX PREFIX TAG TAG DEFICIENCY) MM194 16.03.11.075.10(a) Approval of Human Rights MM194 MM194 Committee Please refer to W262 Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262. <u>MM196</u> MM196 15.03.11.075.10(c) Consent of Parent or MM196 Guardian Please refer to W263 Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263. MM197 MM197 MM197 16.03.11.075.10(d) Written Plans Please refer to W289 is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W289. MM336 MM336 16.03.11.110.04(b) Emergency Plans MM336 Please refer to W449 Emergency plans must be thoroughly tested and used as necessary to assure rapid and efficient function. This Rule is not met as evidenced by: Refer to W449. MM537 MM537 MM537 16.03.11.210.01(b) Documentary Evidence Please refer to W111 Documentary evidence of the resident's progress and of his response to his habilitation program; This Rule is not met as evidenced by: Bureau of Facility Standards (X0) DATE

PAGE 16/17 * RCVD AT 7/15/2009 11:54:03 AM [Mountain Daylight Time] * SVR:DHWRIGHTFAX/0 * DNIS:1888 * CSID:208 888 1156

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

* DURATION (mm-ss):07-50

If continuation sheet 1 of 2

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	of Facility Standards	S				FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G009		ER/CLIA MBER:	(X2) MUL A. BUILDI B. WING		(X3) DATE SURVEY COMPLETED		
NAME OF P	ROVIDER OR SUPPLIER	10000	STREET AD	DRESS CITY	STATE, ZIP CODE	06/2	22/2009
COMMU	NICARE, INC #2 BOO		1210 W B NAMPA, I	OONE ST	, 91015, AF 005E		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETE DATE
MM537	Continued From pa	age 1		MM537			
MM725	16.03.11.270.01(b)	QMRP		MM725	<u>MM725</u>		
	implementation of e of care, integrating program, recording initiating periodic re for necessary modi		dual plan of the ress and al plan nts. This		Please refer to W159		
MM860	16.03.11.270.08(f)((ii) Recording Progres	s	MM860	<u>MM860</u>		
	Recording each res This Rule is not mo Refer to W252.	sident's progress; and et as evidenced by:			Please refer to W252		
ureau of Fa	cility Standards			9889	220D11	If continue	ation sheet 2 of 2